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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/03/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient Left Shoulder Scope w/Open SAD LOS

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Orthopedic surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review

Utilization review

Texas Mutual Insurance Company response

MRI left shoulder

Operative report

Billing records

Office notes

Urine drug screen

Peer review

Office visit notes

Left shoulder MR arthrogram

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female. Records indicate the claimant fell. She complained of mid thoracic and mid low back pain. She also complained of left shoulder pain. Records indicate the claimant had a left shoulder partial tear of the supraspinatus tendon, and underwent surgical intervention with arthroscopy with or underwent left shoulder arthroscopy with debridement,

open anterior subacromial decompression, biceps tenodesis, and repair of supraspinatus rotator cuff tear. Post-operatively she underwent physical therapy/home exercise program. She continued to complain of left shoulder pain. MRI of the left shoulder revealed post-operative changes. Biceps tendon appears to be completely torn from its origin and its intraarticular portion is not visualized (did patient have tenodesis at time of surgery?). There was slight irregularity of the superior and posterior superior labrum likely post-operative in etiology, with no definitive labral tear identified. Acromioplasty post-operative change also was noted. Physical examination reported physical examination reported left shoulder incisions to be well healed with no evidence of infection. There was pain specifically over the anterior acromion. There was subacromial pain with forward flexion of the shoulder and crepitation. There was weakness in forward flexion, with forward flexion only to 40 degrees. Abduction is 60 degrees with some pain. External rotation was normal. There was mild atrophy of the deltoid muscle.

A request for inpatient left shoulder scope with open subacromial decompression was denied on utilization review dated noting the lack of information regarding the dates and number of sessions of therapy the claimant completed. Additionally the imaging studies of the left shoulder confirmed slight irregularity of the labrum with no definite tear. Given the lack of information regarding claimant's completion of conservative treatments and taking into account lack of imaging studies confirming evidence of an impingement the request does not meet guideline recommendations.

An appeal request for inpatient left shoulder scope with open subacromial decompression was denied on utilization review noting that the additional records submitted for this review indicate the claimant was seen in physical therapy one time. The records do not indicate any additional significant conservative care except for subacromial injection. MRI of the left shoulder failed to demonstrate significant pathology in the shoulder to warrant the surgical intervention.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The request for inpatient left shoulder scope with open subacromial decompression is not indicated as medically necessary. The claimant underwent left shoulder surgery. She continued to complain of left shoulder pain and weakness. Claimant reportedly underwent physical therapy post-operatively; however, there was no comprehensive history of the nature and extent of conservative care completed following surgical intervention. MRI of the left shoulder revealed post-operative changes, with subscapularis tendinosis versus post-operative change, with slight irregularity of the superior and posterior superior labrum noted, likely post-operative in etiology. Given the lack of significant findings on imaging, and the absence of documentation of conservative care completed following surgery (other than subacromial injection), medical necessity is not established for the proposed surgical procedure and previous denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES